eMediateINFUSIONcenter

PICC/LABS/TEACH

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx:

Patient Name: | **DOB:**

PICC:

☐ Weekly Dressing Change
☐ OK to DC after the Treatment

LABS:

☐ CBC, CHEM, CRP, ESR
☐ CPK

ANTIBIOTIC TEACH:

☐ Teach on 1st dose

Attached documentation for PICC line placement confirmation.

☐ CXR ☐ Ultrasound ☐ _____

REMINDER:

Please send all supplies needed.

MEDICATION:	***ICD10 Dx:***

Where to send results:

Phone #: _____ **Fax #:** _____

Physician/RPH Signature | **N P I #:** | **Date: (Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | **CLINIC:**

Contact Information: **Phone:** | **Email:**
Fax: | **Other:** s

Office Mailing Address:

Please include the following:

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis (supporting) ☐ History and Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication List ☐ Other Test Results